Arnold Schwarzenegger, Governor

The California Managed Risk Medical Insurance Board
PO Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 FAX: (916) 324-4878

Managed Risk Medical Insurance Board
HFP Advisory Panel Meeting Summary
August 11, 2009
West Sacramento, California

Attendees: Jack Campana, Karen Lauterbach, Leonard Kutnik, M.D., Steven Tremain, M.D.; William Arroyo, M.D., Martin Steigner, D.D.S., Takashi Wada, M.D., Ellen Beck, Elizabeth Stanley-Salazar, and Ron Diluigi.

MRMIB Staff: Lesley Cummings, Ernesto Sanchez, Shelley Rouillard, Ginny Puddefoot, Mary Watanabe, Muhammad Nawaz, Raymond Titano, Ruth Jacobs, Theresa Skewes, Adriana Valdez

Introduction

Jack Campana, Advisory Panel Healthy Families Program (HFP) Chairperson, opened the meeting by introducing himself and asking the Panel members, Managed Risk Medical Insurance Board (MRMIB) staff, and the audience to introduce themselves. He asked that Item 6 of the agenda be delayed until the end of the meeting. Don Kingdon, a member of the California Mental Health Directors Association, is coming later.

Review and Approval of the February 10, 2009 HFP Advisory Panel Meeting Summary

The Advisory Panel approved the May 12, 2009 HFP Advisory Panel Meeting summary.

State Budget Update

Lesley Cummings, Executive Director of MRMIB, informed the Panel about final action on the HFP Budget. It is short $194 million in state funds (which is times two for federal funds). Fifty million of the $194 million was via a line item veto by the Governor. The Senate Pro Tem, Darrell Steinberg, has indicated that the Governor was not able to veto funds and will be pursuing the matter in court.

State Legislation

Ginny Puddefoot, Deputy Director of Health Policy, Legislation and External Affairs, discussed legislative reports. She referred to AB 1383 (Jones) that would raise revenue by changing requirements for hospitals to pay fees which would be redistributed after drawing down federal funding. The funding would be based on the amount of Medi-Cal coverage the hospitals are providing. In that bill there is a

provision that $80 million of the revenues each quarter will be designated to children's health.

Healthy Families Waiting List Updates
Ernesto Sanchez, Deputy Director of Eligibility, Enrollment, & Marketing Division, reported that the waiting list as of July 28th was about 33,000. MRMIB will provide a more updated number at Thursday's Board meeting, a figure that will be closer to 50,000, as the number grows rather quickly. Jack Campana reminded the Panel that the waiting list started on July 17, 2009 – so this proves how large the waitlist grew in such a small period of time (11 days since last update). Elizabeth Stanley-Salazar asked if the amount of people applying will plateau or freeze. Ms. Cummings reminds the Panel that HFP was getting new enrollments of about 33,000 a month before the waitlist was put into effect. She did not know what would happen on the waiting list although families certainly could feel discouraged from applying.

Lesley explained that the next step the Board can take to reduce cost is to disenroll children during their Annual Eligibility Review (AER) starting October 1st. HFP would still have a deficiency of about $68 million by the end of the fiscal year. The Board will discuss this on Thursday. It is very likely that the Board will make the determination that disenrollments occur at AER.

Regarding the efforts to obtain funding for HFP, State First 5 Commission is meeting at the same time as the Board on Thursday to discuss making an offer of assistance to HFP. The advocates are hopeful that receipt of funding from First 5 would allow the Board to defer a decision on AER disenrollments. $23 million would be needed to delay AER disenrollments from October to November.

Dr. William Arroyo, representing the L.A. County Department of Mental Health, asked if there has been any strategy made to approach the local First 5 Programs. Lesley stated that the administration is drafting a letter to the locals. The Legislative leadership sent a letter to the state First 5 Commission for help for HFP. First 5 did provide assistance last year for some children 0-5 years old.

People have asked what it is that the plans can do and what other changes can be made. Plans and advocates had come up with a list of ideas – which is included in the HFP Advisory Panel Packet as Item 5.a.3. It includes a list of benefit changes such as making higher co-pays at emergency rooms, inpatient substance abuse, and etcetera. The Board will discuss this issue more during the Board meetings in August. In terms of health plan rates, the Board agreed to restore the rate cut plan received last year. This is about a 5% restoration.

Ms. Cummings reminded the Panel that MRMIB does not currently administer co-pay increases based on income. Doing so would increase the complexity of the administration of the program. If MRMIB were to do so, it would require a change in regulations. MRMIB tells everyone that premiums and changes in benefits take

four and a half months to manifest down on the physical plane. It is best done in the context of open enrollment.

Follow Up on Plan Performance
Shelley Rouillard, Deputy Director for Benefits & Quality Monitoring updated the Panel about the discussion the Panel had the last meeting regarding adolescents. MRMIB staff identified the top performing plans which are: San Francisco Health Plan, Cal Optima, Health Plan of San Joaquin and Kaiser. MRMIB's chair of the Advisory Committee on Quality facilitated the conference calls with the plans to find out what were some of the best practices that made them so successful compared to some of the other plans. Plans shared different programs they had undertaken, such as provider education and toolkits that they had used to help providers feel more comfortable talking to teens about risky behaviors and health counseling. MRMIB staff then held a conference call with the lowest performing plans in these measures and shared what was learned from the higher performing plans. MRMIB asked the lower performing plans to take action to try to increase their scores and activities around adolescent care. Overall, the plans were interested in doing something. MRMIB will follow up with these plans in about six months – a subsequent conference call is set for January –to find out what progress has been made. The medical directors at the higher performing plans were willing to help the other plans.

Dr. Ellen Beck asked if any of the lower scoring health plans were mentioning any challenges that they were facing. Ms. Rouillard replied that overall, adolescent care had not had a top priority for them, but bringing it to their attention and raising their awareness will make this a bigger priority. Ms. Rouillard also stated that CHIP reauthorization is going to require MRMIB to report CAHPS results to the federal government.

2007-2008 Grievance Report
Raymond Titano reported on the Grievance Report for 2007 and 2008e. The data MRMIB gets from the plans is self reported. Overall, one-half of one percent of subscribers filed grievances with their health plans. For dental and vision, the numbers were a lot lower. For health plans, there are five general categories and then subcategories. For more details on the report, see the link below:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.h_2007-08_Grievance_Report.pdf

MRMIB has been contacting some of the plans that have the highest grievance rates. There are five plans that had the highest rates of grievances. MRMIB has been following up with these plans to discuss their grievances in particular areas.

Jack Campana pointed out that if people think their children might be disenrolled, there could be a surge in the number of children going to the dentist. Shelley agreed that there is a concern about the rush for children to get into the doctor, dentist, or optometrist if families think that their children may be disenrolled.

2007 Dental Quality Report

Mary Watanabe summarized the 2007 Dental Quality Report. She began with a summary about the dental consumer survey, which is called D-CAHPS. MRMIB has been collecting dental quality information since the beginning of the program. Measures were initially developed by a dental advisory committee and collected for the past ten years. There have been a lot of changes in the dental industry and in what is considered standard practices of care in the last ten years. In 2007, MRMIB created a Dental Advisory Committee to look at the existing dental quality measures. The Advisory Committee and MRMIB staff concluded that the measures were outdated and didn't provide meaningful information about the dental services the children were receiving. The Advisory Committee proposed several new measures, which plans are reporting for calendar year 2008. MRMIB will be reporting the new set of data. The list of measures is located on page one, of the report found here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes/061709/Agenda_Item_7.i_2007_Dental_Quality_Report.pdf

MRMIB hopes that these new measures will provide more meaningful information. The measures are more detailed about the types of services that children are actually receiving. Ms. Watanabe is in the process of analyzing that data now. Hopefully the report will be available in the fall. At this time, there is no funding for the D-CAHPS survey or any other patient satisfaction survey for the current year.

CHIPRA requires detailed reporting on dental services. CMS has contacted MRMIB about the dental quality measures for HFP and has asked their national advisory committee to look at the HFP measures and potentially implement these quality measures nationwide. California is the only state that has implemented dental quality measures.

The Advisory Panel is deeply concerned about the results of the Dental CAHPS and wants the Board to reconsider contracting with the dental capitated plans based on their poor performance. The Panel expressed the need to bridge the performance gap between the capitated plans and the fee for service plans.

Ms. Watanabe noted that one of the interesting things about the survey results from the question: "Did you take your child to the dentist within the last 12 months?" About 70% of responders said yes, but the HEDIS results showed overall only 59% of HFP children had an annual dental visit. There is a difference between self reported results and the actual clinical data.

Report on OE Transfers

Ernesto Sanchez addressed 2008 Open Enrollment (OE) Transfers. This is the open enrollment for 2008, as the state had a delayed budget this past year and the budget was not available until late October. The budgetary changes that were

implemented included a premium increase and a 5% plan rate cut. MRMIB put these changes out in November/December of last year and they took effect in February 2009. This report describes the number of people that went through the OE this year. It was the largest transition of any OE group in the history of HFP. Please refer here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052009/Agenda_Item_7.c_2008_Open_Enrollment_Results.pdf

The normal OE period starts in April and runs through May annually. The transfers become effective July 1st. MRMIB will have a report available on the 2009 OE within the next few months. However, the numbers of movements have not been as significant as 2008 OE because there were not as many major plan changes.

Shelley pointed out that a few counties switched their EPO to an HMO so all of those applicants had to pick another plan. They did not necessarily go into the Blue Cross/HMO. This will account for some of those numbers.

Mental Health Services

Ruth Jacobs, the Assistant Deputy Director of Benefits & Quality Monitoring Division, reviewed the options paper on Serving Children with Serious Emotional Disturbances (SED). The purpose of the options paper was to begin a discussion with the Legislature, the Governor's office, advocate groups, plans, county mental health directors, and others about how MRMIB can best serve children with SED. MRMIB staff receive calls from counties and plans about issues that come up with the SED carve out. MRMIB wanted to share these issues with the Board and outline some options for the Board's consideration.

SED is defined as a mental disorder that is other than a primary substance abuse disorder or developmental disorder, which results in behavior that is inappropriate for the child's age (based on developmental norms). These kids have substantial impairment. The child may also show psychotic features, such as risk of suicide, or the child has special education needs. Health plans are required to refer a child to a county mental health department if the provider determines that the child may have an SED condition. One thing that sometimes causes confusion is that it is the county mental health department that makes the determination whether or not the child has an SED condition, not the plan. If the county determines that the child has SED, the county is supposed to provide the necessary services to treat the SED. However, if the county does not have the capacity to treat the child, the HFP plan is responsible to do so. In addition, the HFP plan remains responsible for all other care of the child including immunizations and treatment for any other mental disorder.

There are a number of issues with SED, including the payment for prescription drugs for children, CHIPRA, and the continuity and coordination of care. Most of the services that the child receives from the county mental health plan are billed

through the Medi-Cal system. However, there is no system for counties to bill the state for the cost of prescription drugs. MRMIB doesn't know how many times the families are paying for these expensive drugs or how many times the children are without the drugs.

Another issue is the mental health and substance abuse parity provision of CHIPRA which prevents any state that offers mental health and substance abuse services to have financial requirements and treatment limitations that are more restrictive than those for medical and surgical benefits. Any limitations in mental health or substance abuse services currently in HFP will have to be eliminated. MRMIB will remove benefits limitations for basic mental health and substance abuse problems and this will impact state costs and plan rates. Ms. Rouillard stated that the provisions of mental health and substance abuse parity require a state law change, so this provision would take effect on January 1, 2011, assuming legislation is enacted next year.

The last issue relates to continuity and coordination of care. HFP members must use two systems to receive their health and mental health care. This can lead to problems with different drug interactions, or primary care doctors and other providers not knowing what treatment or medication a child is receiving for mental health or substance abuse conditions.

Staff outlined several options to the Board. First, MRMIB could choose not to provide mental health or substance abuse treatment in the HFP. MRMIB would be in compliance with CHIPRA, which does not require mental health and substance abuse treatment to be covered benefits. Second, MRMIB could provide mental health and substance abuse services through the Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Under CHIPRA mental health services provided through EPSDT, the mental health and substance abuse requirements of CHIPRA are deemed to meet. A third option is to remove the SED carve out and provide all mental health and substance abuse services through the HFP health plans. The fourth option is to carve in prescription drug costs to the plans for HFP children with SED. County mental health departments would continue to provide all inpatient and outpatient services for children with SED. The fifth option is to maintain the status quo.

The Board wants to continue the discussions about this issue and acknowledges that this is a big problem. The Board is very interested in hearing from other interested parties about this issue.

Dr. Beck indicated that maintaining the status quo should not be an option because the current system does not adequately treat children. She thought that having plans take full responsibility, with the option of allowing them to use county services through a contract, would be the best way of serving children with SED.

Ms. Rouillard introduced Don Kingdon, the Deputy Director and Small Counties Liaison from the California Mental Health Directors Association (CMHDA). CMHDA submitted a letter to the Board which was included in the Panel's packet. Mr. Kingdon stated that CMHDA made no recommendations regarding this issue because there are 58 counties and 58 different opinions. He noted that there were a couple things to keep in mind as MRMIB considers what to do about this.

There are many entry doors to the counties which are outlined in the CMHDA letter. The first one is special education, the so-called AB 3632 system. Referrals have started to increase again in the special education system across California. Over the last couple years there had been a decline in referrals that led to concern about the Legislature pulling back funds, however referrals have increased. There are a number of complicated mechanisms for reimbursement to the counties but it can take 3 to 10 years for counties to be paid for serving the special education population. One thing to keep in mind is that this will always require a fair amount of coordination.

Another is the county obligations to provide involuntary treatment. It is unknown how many HFP children experience it, but the counties do have the obligation to either provide the service directly or through contract with other entities.

Dr. Arroyo noted that EPSDT is "the best mental health plan in the country" and that services include rehabilitative services and target case management both of which are options that CA provides. The biggest challenges for counties are that HFP reimburses 65 cents on the dollar. At one time, when counties had reserves associated with "re-alignment" (e.g., sales tax, licensing fees) counties were better able to carry the 35 cents on the dollar cost obligation. Sales tax and licensing fees have tanked over the last few years. County reserves have dried up and now they are operating on a cash basis.

Covering the 35 cents on the dollar has become a big problem for the counties. The SED definition that is in the welfare institutions code is a "realignment" definition and largely applied for "uncovered indigent children." It does not line up well with other definitions. It has a substance abuse exclusion, which is unusual. EPSDT does not have this exclusion. The definition was really designed to provide a threshold for a non-entitlement program and was very conservatively designed on purpose. At the point of realignment, there were two entitlement programs and one non-entitlement program realigned – HFP being the non-entitlement program, the other two being indigent health and foster care. There is a third SED definition and this is the educational definition which an entirely different set of criteria associated with it. Counties do apply that definition along with special education.

Dr. Kutnik asked Mr. Kingdon to share which options CMHDA does not want. Mr. Kingdon replied that the EPSDT option is not politically feasible. He said that it

would help if counties could get federal financial participation (FFP) for prescription drugs. Mr. Kingdon strongly supports fixing the problem with the payment for prescription drugs.

Ms. Salazar wondered how the health plans could absorb providing services to children with SED and what works for Kaiser. Mr. Kingdon replied that Kaiser has a well-developed treatment system but is geographically limited. He said the counties are particularly important in rural areas. Mr. Tremain noted that Kaiser also keeps their members for life. Other health plans have no such relationship with their members.

Mr. Campana stated that there should not be separate mental health programs.

Mr. Kingdon said he thought the MOU between the health plans and the counties should be strengthened while MRMIB and the counties work on these issues. He said there is value in making sure the MOU reflects current practice and is taken seriously. If the county can not provide the service, it should not sign the MOU. He also said that the MOU should define the set of benefits available in the county.

Dr. Beck suggested the need for a change in the definition of SED should be included in the options paper. She wondered if there is a mixed model solution. She further commented that it would be impossible to have HFP without mental health and substance abuse treatment.

Dr. Arroyo said HFP could eliminate the benefit and counties will incur these costs anyway. Mr. Kingdon stated that federal parity shifts the burden from the counties to the plans. Counties could give up the benefit and point people to the plan. Dr. Arroyo then stated he thought Phases 2 and 3 of the mental health evaluation should be completed before making a recommendation on this issue.

Informational HFP Reports

Ernesto Sanchez presented to the Panel a number of informative HFP reports for their review. To access these reports, please click on the links below the agenda item.

a. Enrollment and Single Point of Entry

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_073009/Agenda_Item_7.b_HFP_Enrollment_Report.pdf

b. Administrative Vendor Performance Report

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_073009/Agenda_Item_7.c_HFP_Adm_Vendor_Perf_June_2009_Summary.pdf

c. Enrollment Entities/Certified Application Assistants Reimbursement Report

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_073009/Agenda_Item_7.d_EE_CAA_Quaterly_Payment_Rpt_07.30.09.pdf

d. Federal Funding for Recent Legal Immigrants
http://www.nytimes.com/2009/07/19/us/19chip.html

e. Adoption of Emergency Regulations Concerning Immigration Verification
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_073009/Agenda_Item_7.f_ER-4-09_HFP_Immigration_Verification_Proposed_Regulation_Text.pdf

f. CHIP Reauthorization Implementation, Including:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_032609/Agenda_Item_7.f.pdf

i. Posting Dental Providers on CMS Website

ii. Outreach Grants
http://www.cms.hhs.gov/CHIPRA/Downloads/CHIPRAOutreachGrantsQuestionsAnswersFirstSet071609.pdf

iii. Work Plan Update
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052009/Agenda_Item_7.j.i_CHIPRA_Impacts_and_Implementation_MRMIB_and_DHCS.pdf

Mr. Campana asked if there were any more comments or questions. There being none, he adjourned the meeting.